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Between Stonewall and AIDS: Initial Efforts to Establish Gay and Lesbian Social Services

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Little has been written about gay and lesbian communities' efforts to address health and human service concerns prior to the HIV/AIDS crisis. This article analyzes content from The Advocate along with organizational documents from the early 1970s to explore the health issues addressed by these fledgling providers. Major concerns identified include social adjustment to a gay or lesbian identity, chemical health, sexual health, and family supports. These findings depict a service context strained by funding instability, workplace turmoil, neighborhood hostility, and high levels of consumer needs that would later come to characterize the complex nature of AIDS service work.

Key words: *Gay men, lesbians, health care, social services, community centers, Stonewall, HIV/AIDS*

Much of the attention paid to post-Stonewall social movements organized by gay men and lesbians has focused on activism that challenged discriminatory laws and policies, pioneering political figures like Harvey Milk in San Francisco, or AIDS-related activism starting in the 1980s. While a visible and sustained advocacy movement is now widely recognized in the United States, little has been written about the ways in which gay men and lesbians also identified unique health and human service concerns as they began to form visible communities in the years between the Stonewall Riots of 1969 and the onset of HIV/AIDS in the late 1970s. This article will explore the problems gay men and lesbians identified and attempted to address during a period when homosexuality was still predominantly viewed as a criminal, pathological behavior that

invited numerous public consequences including arrest, loss of employment or housing, verbal harassment, physical violence, and sometimes death. (Recognizing that current nomenclature includes a more expansive range of sexual minority identities including bisexual and transgender individuals, this article uses the terms “gay” and “lesbian” to reflect the predominant self-descriptions of community members at that time.)

While advocacy to the larger public has resulted in significant gains for gay and lesbian civil rights, this paper argues that the history of these communities includes a lesser-recognized component, which illuminates the inward-looking efforts of professional workers and volunteers—for the most part in urban areas—who collectively took an interest in developing gay-affirming responses to the medical and psychosocial problems occurring among their contemporaries. In light of the devastating impact that HIV/AIDS would have in the coming decade, the accounts of these early providers collectively inform our understanding of an emerging community health movement that, although unprepared for a crisis of this magnitude, was beginning to develop a range of professional services tailored to address its members’ biological, psychological, and social needs.

Background

This paper will address three main questions. First, what health and social service issues did gay men and lesbians who participated in urban post-Stonewall community development identify as uniquely impacting their peers due to sexual minority status? Second, what solutions did community members propose for addressing these needs, and to whom did they assign responsibility for carrying out these solutions? Third, what challenges did these fledgling providers encounter during this era, and how did they work to overcome setbacks?

The period examined here—roughly 1969 to 1976—is significant due to the Stonewall riots’ galvanizing influence on an emerging cohort of militant activists across the United States, the American Psychiatric Association’s 1973 declassification of homosexuality as a diagnosable mental illness, and the retrospective discovery that Human Immunodeficiency Virus (HIV) had entered and disseminated among gay men in the United

States by the late 1970s (Quan et al., 2002). The history of gay-identified health organizations during this period can be found in a variety of disparate collections concerning gay and lesbian social movements, including administrative records, personal documents, individual interviews, and news articles from communities across the U.S. The sources available primarily depict the efforts of urban gay men and lesbians, a reflection of both the limitations of rural avenues for building visible gay-identified movements during this period and also the trend during post-World War II decades of gay and lesbian migration to larger cities where social support and political strength could be found in greater concentration (Kaiser, 1997).

Most of this content analysis concentrates on materials published in *The Advocate*, a Los Angeles-based gay and lesbian newspaper with a nationwide scope that has covered a broad range of topics since its launch in September 1967 (Kaiser, 1997). While numerous gay and lesbian periodicals came into existence before and since its initial launch, *The Advocate* offers an especially robust source for understanding issues concerning gay-identified communities at the time, given the stability of its business operations and its ability from early on to collect and disseminate news stories from sources across the nation. Published bi-weekly during these years, by the middle of the decade its nationwide distribution had reached 40,000 copies per issue and it had gained a reputation as "the most important gay-owned and operated magazine in America" (Kaiser, 1997, p. 172).

Content from late 1969 through 1976—including news briefs, articles, in-depth special reports, and advertisements—was analyzed first to determine the extent to which health and social service issues were addressed in gay-related news and commentaries of the time, and second to discern the extent to which the gay and lesbian community's attention to these issues had expanded by the end of this relatively brief period. Examples drawn from *Advocate* stories were corroborated with a small sampling of organizational papers from this period to illustrate how gay men, lesbians, and their fledgling community organizations addressed these challenges in practice, policy, and public discourse.

Supportive Organizations Predating Stonewall

A number of historians have documented how, despite the fact that homosexuality was widely viewed as both a crime and a psychopathology, homosexual or homophile-identified people made efforts to change discriminatory attitudes and policies prior to 1969. Homophile support and advocacy organizations such as the Mattachine Society and Daughters of Bilitis, and gay veterans' groups emerged in the MacCarthyist years following World War II, when the very act of organizing a pro-homosexual movement presented a number of risks for these early advocates. Suspected homosexuals encountered monitoring, surveillance, and occasional blackmailing, not only in bars and public cruising areas, but also social meetings and mail sent through the U.S. Postal Service (Carter, 2004; Charles, 2010; Kaiser, 1997; Marcus, 1992). Still, gay men and lesbians during this time found ways to reach out and form supportive networks that focused primarily on establishing safe social spaces (often in private homes) and advocating for legal reform by emphasizing respectability and human dignity (Carter, 2004; Kaiser, 1997; Marcus, 1992).

The argument for relaxing anti-gay policies was bolstered in the 1950s and 1960s by key behavioral studies including those of Alfred Kinsey and Evelyn Hooker. However, it was Stonewall, a June 1969 weekend of violent clashes between Greenwich Village gay bar patrons and New York City police officers, that served as the catalyst for an emerging militant movement that both demanded acceptance from mainstream society and exhorted gay people to "come out" and gain political strength in numbers (Carter, 2004; Kaiser, 1997; Marcus, 1992). In the ensuing years, this movement would expand across many parts of the United States, with constituencies in larger cities such as New York, Los Angeles, and San Francisco spearheading the development of new community structures to meet the health and social support needs of gay men and lesbians across a range of issues and concerns. The sections to follow will identify these nascent communities' major health concerns during this period and show examples of how they organized and delivered services, along with how workers found resourceful ways to cope with the numerous obstacles they encountered.

Health and Social Service Concerns Identified Post-Stonewall

The accelerating visibility of the militant movement and its associated media offered opportunities to promote and share supportive resources in a more organized and comprehensive manner than had previously existed. Dating back to late 1969, *The Advocate* highlighted community members' efforts to catalog and disseminate resource guides covering all fifty states, and by the mid-1970s, gay community service centers had arisen and were duly reported from a number of cities, including Costa Mesa, Portland (Maine), Dallas, Kansas City (Missouri), and Ottawa (Canada). "Advocate Adviser," an advice column featuring a panel of health experts, began responding to readers' inquiries in September 1975 and frequently referred letter-writers to gay and lesbian services operating in their local communities.

Within a few years, some of the earliest organizations, such as L.A.'s Gay Community Services Center, had been awarded sizable public health grants addressing issues such as mental health and venereal disease. Still, the need for affirmative social support remained central to many of these services, with counseling centers and volunteer-operated telephone hotlines attending to individuals' concerns, including coming out, relationship difficulties, or loneliness and isolation (Maves, 1975b; "Women Respond," 1972; Young, 1972). Among the most consistently identified concerns during this period, four specifically stand out: social adjustment, chemical health, sexual health, and family supports.

Social Adjustment to a Gay or Lesbian Identity

While studies have historically pointed to disproportionate levels of mental health problems among sexual minority populations, a great deal of evidence attributes at least some of these disparities to contextual factors, including marginalized status within society, lack of an intimate partner, prior experiences of anti-gay violence and discrimination, sexual victimization, and high levels of community isolation (Bradford, Ryan, & Rothblum, 1994; Meyer, 2003; Mills et al., 2004). To that end, even though this section cites examples of gay-affirming counseling centers, for a number of gay men and lesbians

during this era, having safe space to meet other homosexual-identified individuals represented their first and most pressing need.

For those who struggled to accept and understand their sexual attractions, the availability of supportive resources in mainstream society remained scarce, given that many members of the medical and mental health establishments still adhered to the premise that homosexuality was a mental illness ("Gays to Try," 1971; Marcus, 1992; Maves, 1975b). In the immediate years following Stonewall, movement leaders in cities like New York and Los Angeles focused on securing and maintaining multi-purpose spaces that could accommodate small discussion groups and large-scale meetings, reading rooms, coffee houses, individual counseling sessions, and social alternatives to gay bar scenes ("Gay Community Center," 1971; Gibson, 1970; "WSDG Drives," 1970). The Minneapolis-based Gay House, funded in part with grants from a local Protestant foundation, reached out to gay youth arriving to the city from rural areas while also linking with other relief agencies providing food, job placement, legal services, and other forms of immediate assistance ("Church Group," 1971). Early ventures also included counseling centers staffed by therapists who, contrary to the profession's dominant point of view, would only focus on homosexuality if it was determined to be a "causative factor in unhappiness" while emphasizing, "[I]f homosexuality is a positive function of your life it will not be up for discussion" ("Gays to Try," 1971, p. 2).

Supporting the needs of gay-identified individuals who also experienced marginalization due to other facets of their identity stood out as a consistent sub-theme within the early militant movement. In some cases, groups tried to create their own separate spaces, distinguishable from other gay or lesbian identified structures. For instance, *The Advocate* noted various efforts in the early to mid-1970s to establish separate help centers for gay Latin Americans ("Unidos Plans," 1971), transgender or gender-nonconforming persons ("One Brick," 1971; "Transsexual Help," 1971), and gay men and women who were deaf or hard of hearing (Emery, 1976; "Gay is Good," 1976).

Often, however, efforts targeting such groups as gay youth (Barney, 1971; "One Brick," 1971), gay overeaters ("Miscellany," 1976), and gay and lesbian prisoners and ex-offenders

("Ex-offender Re-entry," 1976; Gregory, 1972b; "Let's 'Join Hands,'" 1972; "News Briefs," 1976; "Stonewall Prison Program," 1972) were simply introduced as new programs within existing community services. Contributor David Rothenberg (1976) even highlighted the efforts of incarcerated gay male prisoners to organize their own supportive nationwide network among those still living "behind the walls" for various criminal offenses. Although a number of these community spaces supported various activities, ranging from counseling and provision of basic needs to support groups and social events, the proceeding sections will illustrate that in a relatively brief span of time, organizations began to identify commonly-held needs beyond those which social support could provide, leading to a rapid and sometimes haphazard growth in funding and infrastructure by the middle of the 1970s.

Chemical Health

The increased visibility of, and access to, gay-identified social spaces led providers to recognize that chemical dependency exerted an especially widespread influence and negative impact on gay men and lesbians already experiencing social stigma and isolation due to their sexual minority status (Hicks, 2000; Kus & Latcovich, 1995; Skinner, 1994; Wong, Weiss, Ayala, & Kipke, 2010). Kus and Latcovich (1995) noted that the unique challenges presented by the intersection of sexual identity and chemical dependency were apparent to Alcoholics Anonymous (AA) co-founder Bill Wilson as early as the 1940s, but gay-identified AA groups would not emerge until several years later. News briefs and articles in *The Advocate* in the immediate post-Stonewall years (1969–1972) noted the increasing proliferation of gay-identified AA and other groups aiming to provide discreet support to individuals "forced to live a schizophrenic existence (straight work world and gay social life)... where alcoholism could be brought about by psychological problems" (Phillips, 1971, p. 12).

By the mid-1970s, a growing number of advocates had concluded that the unique service needs of gay-identified individuals required a different approach than simply carving out space within existing chemical health resources. A series of *Advocate* special reports in 1976 characterized alcoholism in

the Los Angeles gay community as having reached “pandemic” proportions, citing locally-based research estimating that approximately one-third of gay residents were in the danger stages of alcohol consumption (Shilts, 1976a) and noting that “strict” alcoholism—especially among gay men and lesbians—was becoming more scarce, while polydrug use was observed to be more prevalent (West, 1976). The reports identified the limited number of venues for socialization as a contributing factor, with gay bars for men and private house parties among lesbians offering social outlets that did not exist in the heterosexual world. Journalist Randy Shilts (1976a) described the limitations of existing treatment modalities, which included providers who: prioritized treating patients’ homosexuality before addressing their substance use; rejected gay male or lesbian patients upon learning of their sexuality; or, urged gay men and lesbians to remain silent lest they provoke verbal or physical abuse from other patients (Shilts, 1976a). The preferred solution to these problems, the author argued, would be “to have gay people work with gay alcoholics” (Shilts, 1976a, p. 23).

In response to the perceived need for gay-operated chemical health services, a number of treatment centers emerged in cities, including San Francisco’s Alcoholism Services for the Homosexual Community, Seattle’s Stonewall Therapeutic Center, and Minneapolis’ Christopher Street. A jointly-sponsored project of the University of Minnesota and the locally-based Gay Community Services organization, Christopher Street aimed to “enhance the possibility for chemically dependent gays and lesbians to enter the existing continuum of care” while providing equal treatment within this system and offering preventive services for sexual abuse survivors (Shambach, Green, & Ralke, 1976). The project offered direct services not available to gay men and lesbians within existing treatment systems at the time, with the aim of improving gay and lesbian patients’ likelihood of achieving and staying chemical-free (Shambach et al., 1976). Consistent across both the Christopher Street literature and the *Advocate* special reports of the time was an emphasis on the need for sober alternatives to the gay and lesbian community’s existing social outlets. Among its various support group offerings, Christopher Street’s newsletter highlighted ongoing activities that included a lesbian coffee

house night, gay karate classes, movie nights, and a "maverick encounters" group (Shambach et al., 1976).

Despite funding limitations, some chemical health services for gay men and lesbians managed to secure grants from local governments, along with backing from the U.S. Department of Health, Education, and Welfare and the National Institute on Alcoholism and Alcohol Abuse (NIAAA) ("Big U.S. Grant," 1973; Shambach, Green, & Ralke, 1976; Shilts, 1976a). A prevailing sentiment in *The Advocate's* reporting at the time viewed solutions to the growing problem as the responsibility of both the gay community and the government: "[T]ax money is not enough. Nearly every granting organization requires matching funds, or at least expects you to have a community-based following" (Shilts, 1976a, p. 25). To that end, many providers featured in these reports posited that the larger challenge of addressing chemical health would require gay and lesbian communities to develop and underwrite their own sober alternatives to bars and bathhouses (Shilts, 1976a; West, 1976).

Sexual Health

Although gay men's sexual health would draw far greater public attention and scrutiny with the discovery of HIV/AIDS in the 1980s, concerns about sexually transmitted infections (STI) were raised in *The Advocate's* pages as early as 1971. In a first-person commentary detailing his experiences with being tested and treated for syphilis and gonorrhea, contributor Sam Diego described the range of emotions he experienced, first with detecting symptoms and later with receiving an ominous telegram ordering him to report immediately to the local health department (Diego, 1971). Diego's conversational tone communicated both the emotional turbulence of his experiences ("I tried to pull myself together but kept remembering that as a small child I had this rare blood disease...") and the ways in which he used humor to cope with his discomfort ("He asked after each name, 'Did he *pack* you or did you *pack* him?' [author's italics] Pack! I felt like a Baskin Robbins employee") (Diego, 1971, p. 20).

In the early 1970s, a growing awareness of sexually-transmitted infections among gay men evoked increasingly urgent responses that included both a focus on establishing alternative clinics in gay community centers and heightened but

controversial public awareness efforts on local television ("Male Art," 1972; "N.Y. Groups," 1972). By the middle of the decade, sexually-transmitted infections among gay men had become so widespread that an *Advocate* special report characterized the problem—citing sources from Los Angeles, Hawaii, Chicago, Milwaukee, and Washington, D.C.—as "pandemic" and attributed most of the blame to public health officials and medical practitioners who did little to educate or properly screen gay male patients (Shilts, 1976c). The Shilts-authored piece characterized the federal government as "bellyaching" about high infection rates among gay men while neglecting to commit any additional funding to support their specific needs, and also described the response of many private clinicians as "outright hostile" to their gay male patients, preferring to respond to infections as a moral rather than a medical problem (Shilts, 1976c). Shilts documented how local efforts to produce and disseminate gay-friendly sexual health pamphlets encountered resistance from established public health overseers such as the Colorado Action Council on Venereal Disease, which refused to print any materials, and the Minnesota Department of Health, which finally released its first brochure after two years of pressuring from local activists (Shilts, 1976c).

Echoing its views on chemical dependency treatment, *The Advocate* argued that gay-led venereal disease (VD) clinics could more effectively serve gay patients' needs by providing a relaxed, nonjudgmental alternative that offered throat and rectal screening not usually provided by traditional clinic settings (Erickson, 1976; "Helping," 1973). While L.A.'s Gay Community Services Center expanded to include VD services, other cities, such as New York, Chicago, Milwaukee, and Washington, D.C. saw the emergence of new clinics specializing in gay men's sexual health (Shilts, 1976c). Although calls for federal funding of gay venereal disease treatment and prevention would result in limited but still first of its kind government support, Shilts (1976c) noted that the disproportionate number of cases, especially of syphilis and gonorrhea, far exceeded the resources available to test, treat, and prevent infections.

In the absence of a centrally coordinated, government-led response, it was suggested that members of the gay community would need to fashion their own approach to combating the

insurgence of infections. An *Advocate* commentary at the time observed, "Until public health authorities return to us some of our tax dollars in services instead of harassment, we gay people will have to finance this work ourselves" ("Opening Space," 1976, p. 5). Attempted solutions would include building partnerships to offer free, routine testing and treatment at local bars and bathhouses, promoting the desirability of sexual health screenings in print advertisements, and soliciting help from volunteers to augment the small number of staff conducting patient interviews and blood draws ("GCSC VD Clinic," 1975; Shilts, 1976c).

Family Supports

In the 1970s, issues regarding family support as it related to gay men and lesbians emerged as two distinct but overlapping categories. First, an outgrowth of residential services emerged from the early community centers to support gay and lesbian individuals (especially youth and gender nonconforming persons) who, by virtue of their sexual identity, had lost all material and emotional support from their families of origin ("Houston Group," 1971; "One Brick," 1971; Warman, 1971; Wicker, 1973). Liberation House, an early outgrowth of the L.A. Gay Community Services Center, housed up to ten gay male street youth at one time, occupying a leased bungalow in a residential area and quickly gaining recognition from the county's juvenile welfare and general assistance programs. In *The Advocate's* 1971 profile of the new initiative, house overseer John Platania commented,

A lot of us in the gay community were always talking about our responsibilities. We knew we had these hundreds of young guys around—on the bum, starving, lots of them sick and infected, loaded on speed and the whole bit. We all said sure, we've got to do something about this. But we never did." (Warman, 1971, p. 4)

The number of youths who needed assistance was evident almost immediately, as the population of Liberation House was roughly half the number of gay youths who had been sleeping on the floor of an existing organization and, within several weeks it was announced that a second, larger Liberation House had opened as well ("Liberation House," 1971).

The second concern related to family support addressed the unique experiences of families raised by gay and lesbian parents (biological, adopted, or foster). As the militant movement gave rise to an established network of supportive services, a number of existing family service agencies took a proactive interest in gay and lesbian experiences, reaching out, for example, to include gay couples in marriage and parenting counseling ("Hospital's Marriage Counseling," 1970), and in San Francisco naming a gay man and lesbian as representatives to the prominent Family Service Agency ("Family Services," 1971). Within a few states, this increased attention eventually led to some gay-affirming policy shifts. For example, in 1976, Massachusetts' Department of Public Welfare issued the results of a yearlong investigation of the state's foster placement system, concluding that homosexuality in and of itself did not constitute unsuitability for parenting ("No Evidence," 1976) and the State of California ruled that gay adults without histories of mental illness or criminal sexual conduct toward children could be permitted to serve as foster parents ("CA Gay Foster," 1976). However, efforts to recognize and draw on the perspectives of gay men and lesbians faced resistance from a number of stakeholders, including entrenched bureaucrats and judges.

One case illustrating this difficulty came from Washington State and involved Pat Davis, a sixteen-year old gay youth who was placed with Gary McQuiston and John Clark, a gay couple that previously had been deemed suitable to foster based on the recommendations of multiple social workers. Despite the youth's successful adjustment to living with the couple, it was reported that a probate judge immediately revoked the placement when it was brought to his attention, refusing to even formally hear the case in his courtroom (Shilts, 1975a). Similarly, child custody battles resulting from divorce were characterized as nearly insurmountable for many gay and lesbian parents, some of whom faced the additional burdens of proving psychological "fitness" while fearing negative consequences for their children should they introduce a same-sex partner to the household or publicly acknowledge being gay or lesbian (Gengle, 1975; Gregory, 1972a; Maves, 1975a). Additionally, popular responses toward parents from other gay people varied. In San Francisco, for example, while members

of the support group "Gay Fathers United" expressed surprise at the goodwill they received during the annual Pride parade, members of "Lesbian Mothers and Friends" tabling the Castro Street Fair recounted a number of derogatory comments such as "child-hating lesbians" and "[lesbians] who sleep with men" from other gay men and women (Gengle, 1975; Maves, 1975a, p. 33).

Facing a society that still largely viewed homosexuality as harmful to healthy childrearing, and lacking widespread popular support from other community members, lesbian and gay parents formed supportive groups to share their experiences, challenge harmful stereotypes, and provide referrals for legal assistance when necessary ("Aid to Gay," 1972; Gengle, 1975; Maves, 1975a). Although presently a number of research studies exist indicating that children raised by gay men and lesbians are equally advantaged compared to those raised by heterosexuals (Biblarz & Savci, 2010; Patterson, 1995, 2000), gay-identified parents of this era faced a number of social, legal, and political obstacles that in many ways reinforced individuals' isolation from wider circles of support.

Common Obstacles and Responsive Strategies

The challenge of establishing, promoting, and sustaining new services within a population generally regarded as mentally ill, criminally disposed, or nonexistent manifested itself in a variety of obstacles. To some extent, acts of homophobic bias and intimidation exerted their influence as evidenced by accounts of police raids during routine business meetings (Arderly, 1971); refusal of seminary admission to a gay community services coordinator ("Lutheran Seminary," 1971); neighborhood petitions to prevent the opening of a gay substance abuse and ex-offender treatment center (Shilts, 1975b), and; arson ("Seattle Torched," 1976). However, the two most consistent obstacles involved the limited and often nonexistent availability of funding and the organizational instability and turmoil experienced by management and staff.

Limited and uncertain funding stands out as the most persistent barrier across virtually all of these emerging organizations. From the outset of organized gay and lesbian community services, private support from individual donors and

volunteers (often service recipients) helped to underwrite costs to secure, renovate, and maintain spaces; pay for rent and salaries; and cover the expenses for mailings, office supplies, and sometimes even medical supplies (Erickson, 1976; "Gay Community Center," 1971; "Liberation House," 1971; Lewis, 1975; Shilts, 1976c, 1976d). Limited operational support sometimes came from liberal religious foundations and local governments, but organizations struggled to offset their expenses once "seed" funding had run out ("Church Group," 1971; Erickson, 1976; Gay Community Services [Minneapolis] Board meeting minutes, May 20, 1975; "Liberation House," 1971; "News Briefs," 1975; "News Briefs," 1976). At Minneapolis' Gay Community Services for example, a sliding scale fee policy was crafted as an attempt to balance the organization's need to collect some nominal payment with clients' abilities to pay based on monthly income (Livingston-Cohen, 1975).

During this period, the issue of funding equity for gay taxpayers formed part of *The Advocate's* call for increased government support of gay and lesbian health and human services (Shilts, 1976b). In one commentary, editors pointed out that, "Gay people, most of whom are also single, can expect to see at least 32 percent less in real benefits from their tax dollars" ("Editorial: A Taxing Time," 1976, p. 14). This disparity especially irked gay venereal disease workers who witnessed disproportionate impact among their clients, yet faced the added difficulty of having to fundraise for services that heterosexuals were able to utilize for minimal additional costs (Shilts, 1976c). An *Advocate* editorial in 1972 observed,

To say that gay groups are sucking hind tit in the contributions department is putting it mildly. Most of them aren't getting any tit at all. Many gay groups—especially the gay social service organizations—can stretch a dollar further than anyone else we know. ("Editorials: Pride in Being," 1972)

Furthermore, if government funding proved elusive to secure, its arrival brought a more complex set of problems for these relatively young organizations. Washington, D.C.'s Gay Men's V. D. Clinic, heralded for gaining a \$50,000 appropriation in early 1976, later had the money stripped by Congressional overseers who felt that gays could adequately access

treatment through existing mainstream services (Aiken, 1976; "V.D. Bucks," 1976). For L.A.'s Gay Community Services Center, the arrival of substantial government funding brought much-needed support for its venereal disease programs, but required significant additional support for administrative overhead, resulting in the dissolution of the agency's Liberation House programs and transsexual support services, and displacing office space for its prisoner, probation, and parole support services (Lewis, 1975). Seattle's Stonewall Human Growth Center, facing the loss of its NIAAA grant along with a slew of costly mandated facility repairs, opted to cease operations in mid-1976 ("Stonewall is Closing," 1976).

Funding issues inevitably overlapped with instability and turmoil among management and staff for many reasons, chief among them the rapid realization that far more need existed than capacity to address it. Within just a few years of the center's 1971 opening, Gay Community Service Center workers in Los Angeles, often unsure of whether they would be paid on time, reported providing services to approximately 7,500 gay men and lesbians annually through its venereal disease clinic; inpatient and outpatient alcohol and drug abuse programs; prison, probation, and parole services; interim housing; and its telephone switchboard (Shilts, 1976d; Stone, 1975). Managing its expanded operations would prove difficult, however, as the Center's initial overseers—many from the militant movements of the time—resisted traditional executive decision-making models and tried a number of approaches, including collective decision-making, team-based management, and eventually employment of a full-time Executive Director (Lewis, 1975; Shilts, 1976d). A Shilts-authored *Advocate* exposé in 1976 highlighted a number of operational concerns, including: mismanagement of payroll and occupancy costs that had arisen from the increased administrative burden; staff skepticism toward management's attempts to raise funds from wealthy private donors; accusations of "sexism, bossism, and racism" from workers who picketed in an attempt to oust senior management and board members; and public outcry regarding a nightclub's "slave auction" fundraiser intended to benefit several gay organizations, including the center (Shilts, 1976d).

These services' relationships with the larger gay and lesbian community, many members of which were small donors and

volunteers, were tested as well. Reporter Sasha Lewis' (1975) profile of L.A.'s Gay Community Service Center noted that perceptions of having "made it" when federal funds arrived meant that the private support needed to cover overhead costs began to shrink. Rivalries or turf wars between local gay and lesbian agencies were also noted in the staff newsletter of Minneapolis' Gay Community Services (1975), with agencies struggling to differentiate how each performed distinct, unduplicated, and arguably essential functions that merited community support.

In response to these various crises, management and staff responded with as much resourcefulness as time, energy, and circumstances would permit. Employees' efforts went beyond long working hours to include fundraising in the streets to pay the organization's rent, collecting various in-kind donations (including carpeting, an air conditioner, a doorknob for the bathroom, and a working typewriter), and organizing staff potlucks to boost morale (Gay Community Services [Minneapolis] Staff Newsletter, May-June 1975; Shilts, 1976d; Stone, 1975). Archival material from Minneapolis' Gay Community Services illustrate how staff sometimes used humor in meetings and newsletters to help each other cope with these frequent stressors, including brief asides such as, "Methodist Council investigating us and [Lesbian Resource Center] to see if we are promoting homosexuality (distasteful I'm sure);" "Nomination to Board (Sue Bonine)... Motion passed. Welcome to many headaches Sue;" and, "[W]ithout any more Gerald Ford rhetoric..." (Gay Community Services [Minneapolis], Board Meeting Minutes, May 20, 1975; Gay Community Services [Minneapolis] Staff Marathon, June 7-8, 1975, Staff Newsletter, May-June, 1975).

Discussion

Despite the American Psychiatric Association's de-classification of homosexuality as a mental illness in 1973, the social sanction for openly associating with other gay and lesbian people continued to represent a powerful inhibitor in the 1970s. Many of these early community services simply ceased to exist, while those that survived did so despite extremely limited funding, bias from the larger community, and turnover

and conflict among workers and management. Organizations stayed afloat by soliciting private donations from individuals and foundations, renting out space for dances and other groups' meetings, charging nominal fees for services, and employing the efforts of motivated gay and lesbian volunteers (Kayal, 1994). Turmoil was not unfamiliar to these organizations and their constituents, as heated debates arose with respect to financial management, decision-making structures, and the equal representation of underserved voices.

The history of these efforts, although related to other more prominent post-Stonewall social movements, stands as both distinct and significant in light of the monumental challenges presented by widespread HIV infection among gay men—a medical crisis discovered in the early 1980s, but now recognized to have been present since the middle to late 1970s (Quan et al., 2002; Shilts, 1987). Political events in the intervening years would bring unprecedented attention to gay-identified urban centers, but the relative newness of these communities, the presence of social stigma and legal sanctions for intimate same-sex behaviors, and organized backlash from conservative opposition meant that gay and lesbian social services would continue to operate under conditions that would later become associated with AIDS service organizations (ASOs) in the 1980s (Mechanic & Aiken, 1989; Shilts, 1987). The outright refusal of mainstream clinics, hospitals, and nursing homes to accept AIDS patients gave rise to the ASO as a service provider. Much like their post-Stonewall forebears, ASOs would attempt to address a complex set of health and psychosocial needs that compounded the difficulty of treating patients' medical conditions (Kwait, Valente, & Celentano, 2001; Mechanic & Aiken, 1989).

Over the past thirty years, a number of studies have explored various facets of AIDS service delivery, including lessons learned from long-term care for chronic illness in other populations (Mechanic & Aiken, 1989); motivations for AIDS volunteerism (Omoto & Snyder, 1995); provider attitudes toward research-based prevention interventions (DiFranceisco et al., 1999); and the financial health of ASOs in the United States (Ferris, Pike, & Schaeffler, 2007). Their findings, along with recommendations in the federal government's (Office of National AIDS Policy [ONAP], 2010) *National HIV/AIDS*

Strategy for the United States, echo the context depicted in this paper with respect not only to the persistent health disparities impacting gay-identified populations but also the tenuous conditions in which newly-formed gay and lesbian organizations—facing high demand for services and limited public or private funds to operate—struggled to stay afloat.

The Advocate's content addressing these various health and human service issues provoked a variety of reader responses, especially Shilts' stories on alcoholism, venereal disease, and the turmoil experienced by L.A.'s Gay Community Service Center. While some letter writers took issue with how gay and lesbian health problems were presented (and reinforced negative stereotypes about homosexuals), the general theme of concern for fellow gays' and lesbians' health and well-being resonated with readers from different parts of the country (Austin, 1976; Boger, 1976; Brunt, 1976; Hewes, 1976; Hunter, 1976; J. T., 1976; Johnson, 1976; Merino & Richards, 1976; Rod M., 1976; Schwartz, 1976; Shaskey, 1976; Tuttle, 1976). An unscientific *Advocate* readers' poll in late 1974 revealed that while less than half of respondents had utilized gay and lesbian social services, wide majorities viewed the services both as necessary and trustworthy ("Advocate Poll," 1974; "Gay Agencies," 1974).

On a related note, frequent contributions on these topics stand out from freelance journalist Randy Shilts (now deceased), who would later author *The Mayor of Castro Street: The Life and Times of Harvey Milk* (1982), the bestselling *And The Band Played On: Politics, People, and the AIDS Epidemic* (1987), and *Conduct Unbecoming: Gays and Lesbians in the U. S. Military, Vietnam to the Persian Gulf* (1993). Despite the limitation of relying on one author's viewpoint to represent a number of concerns from this period, Shilts' articles routinely cited multiple sources from across the U.S. to support his arguments, taking care to highlight the limitations of his data when presenting his conclusions. Further study of Shilts' life history and personal outlook would be useful for understanding his influence on gay and lesbian community health initiatives during this period.

Conclusion

The purpose of this paper is to explore health and human service concerns that gay men and lesbians identified and attempted to address during the rise of post-Stonewall gay movements of the early to mid-1970s, prior to the AIDS crisis of the 1980s. An analysis of news and organizational content from this period illuminates the efforts of a community that was growing increasingly concerned with issues of social adjustment, chemical health, sexual health, and family supports while struggling with obstacles that included bias and intimidation, resistance and outright hostility from various governmental entities, limited funding, and turmoil among workers.

Although this analysis identifies concerns within a broader conceptualization of gay and lesbian identity, further research would be helpful to better understand the differential experiences of lesbian women, transgender and gender-nonconforming individuals, bisexuals, communities of color, youth, and disabled gays and lesbians. Additional investigation would also help address the question of similarities or differences between gay and lesbian social services' formative experiences and comparable providers that emerged from the social movements of other marginalized U.S. populations. Despite these limitations, this article contributes to the larger understanding of sexual minority health issues by presenting preliminary evidence that for much of the decade prior to the discovery of AIDS, members of the gay and lesbian community recognized health and human service needs that uniquely impacted their peers due to sexual minority status, determined that addressing these problems could be done more effectively by individuals and organizations that shared the same sexual minority status, and, in the face of numerous obstacles, found resources to support their initial efforts.

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